CLEAR

MEMORIAL UNIVERSITY

INTERNAL REQUISITION
FACULTY OF MEDICINE

Recommended Supplier:

_____

_____

_____

_____

_____

Supplier Phone Number

Fax Number:

THIS BLOCK MUST BE COMPLETED

Date _____ Yr. _____

SUPERVISOR:

FACULTY DEPT.: (with Medicine):

REQUISITIONED BY:

FOAPAL: _____

PHONE NUMBER: _____ ROOM: _____

DELIVER GOODS TO: _____

SPECIAL INSTRUCTIONS: _____

Item	Qty.	Catalogue No.	Qty. Rec'd	Description	Unit Cost	Total Cost

Freight	
Sub Total	
G.S.T.	
HST	
Total	

Approved: _____ Funds avail./Sign auth.

Approved: _____ Faculty, Director or Supervisor

_____ Received by

_____ Date

☐ Credit Card

☐ Purchase Order